STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Iowa Medicaid
IOWA HHS

Psychiatric Intensive Care Payment Model and Intensive Residential Service Homes

Iowa Medicaid
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Overview


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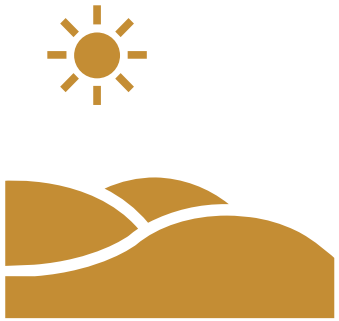
Background



PIC Background

- In 2022, the Iowa legislature passed a bill directing the development of a psychiatric inpatient care (PIC) reimbursement rate for Medicaid.
- This bill required Iowa HHS to start a tiered-rate reimbursement model for psychiatric intensive inpatient care under the Medicaid program. This was based on member acuity.
- This rate went into effect January 1, 2023.

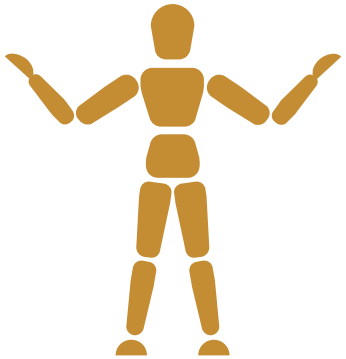
Tiered Rates

The tiered rate consists of:

Existing General Psychiatric Inpatient Care Rate

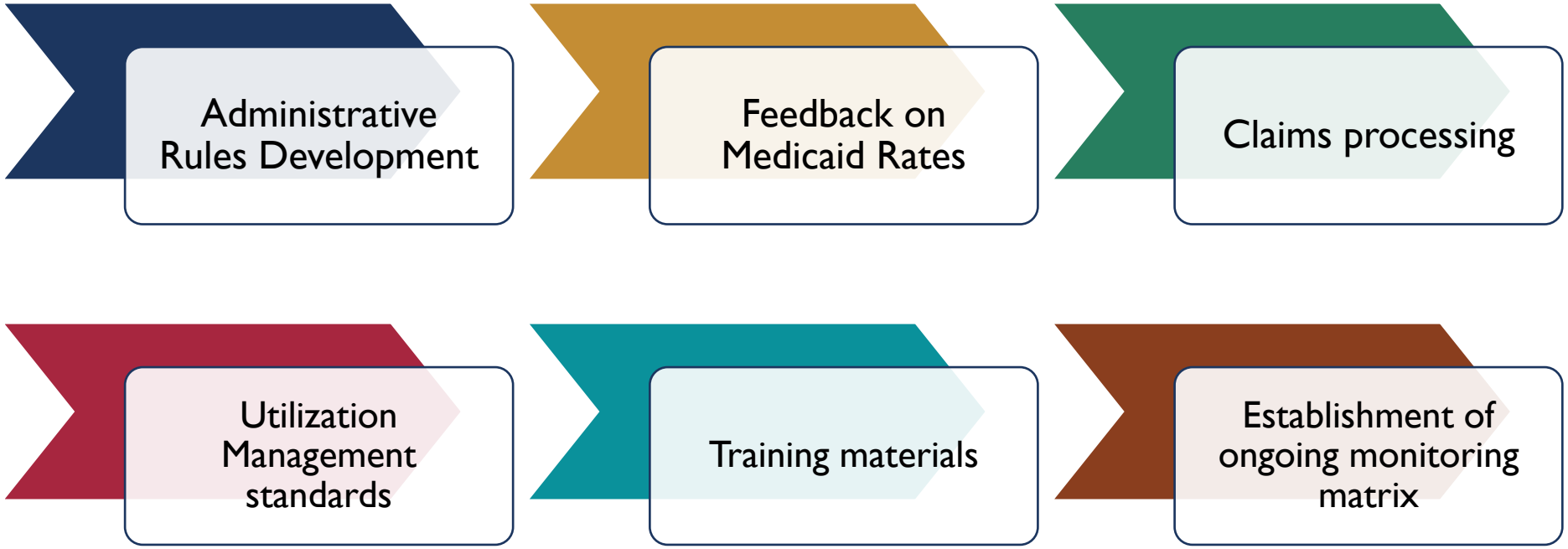
New Psychiatric Inpatient Care Rate

Model of Care Development

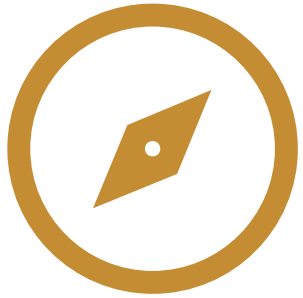


Process of Model of Care Development

Iowa Medicaid partnered with the Iowa Hospital Association and developed a workgroup of providers to assist with this project.



Clinical Guidelines



Clinical Guidelines

Pt. 1

PIC services are medically necessary when the following criteria are met:

Member must be between 18 and 64 years of age.

Member has a serious mental illness as defined in 441—subrule 77.47(1).

Member has a current, severe, imminent risk of serious harm to self or others.

Clinical Guidelines

Pt. 2

Displays additional complexity of need related to **one** of the following:

- Complex behavioral illness, including intellectual or developmental disability, autism spectrum disorder, substance use disorders or traumatic brain injuries.
- History of violence or current aggression that is secondary to mental illness.
- A request for member transfer that has been rejected by inpatient level of care by one or more hospitals due to severity of symptoms.
- Lack of responsiveness to typical interventions or a condition that is treatment refractory.
- Disorganized psychotic state or manic thought process that impairs the ability to function or risks the safety of the patient or others.
- Actively suicidal or homicidal.
- Behavior that causes significant disruption to the general milieu of the unit (i.e., instigating other patients in negative ways).
- High elopement risk.
- Any other atypical reason that the treating mental health provider feels that additional resources are needed to keep the member and others around the patient safe.

Clinical Guidelines

Pt. 3

The member must have a documented need for acute intensive psychiatric care requiring increased or specialized staffing, equipment, or facilities, based on **two or more** of the following:

Fall precaution protocol in place.

Restraints or seclusion room requirements.

Requiring assistance with activities of daily living.

Requirements for complex nursing care.

Acutely impaired cognitive functioning.

Documentation of interventions to address acute complex mental illness and comorbidities.

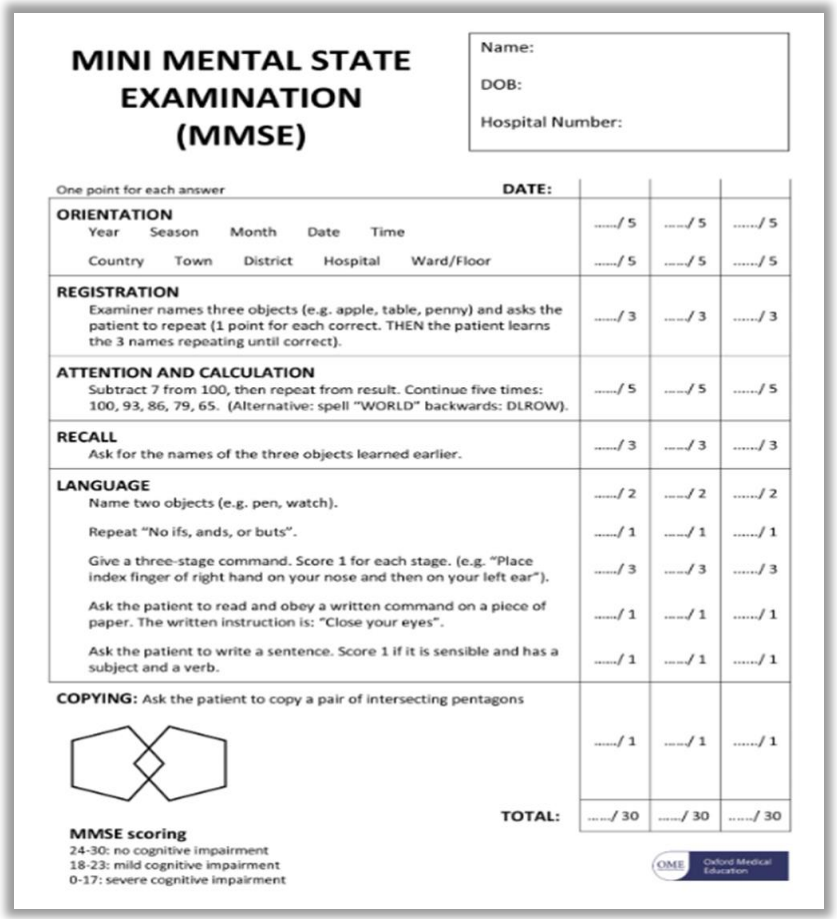
Safety protocols in place to address the physical risk posed to staff, other patients, and infrastructure.

Elopement risk precaution protocol in place.

Cognitive Assessment Scale Examples

Use of these specific scales is not required, but similar scales may provide supportive documentation.

Mini Mental State Exam (MMSE)



MINI MENTAL STATE EXAMINATION (MMSE)

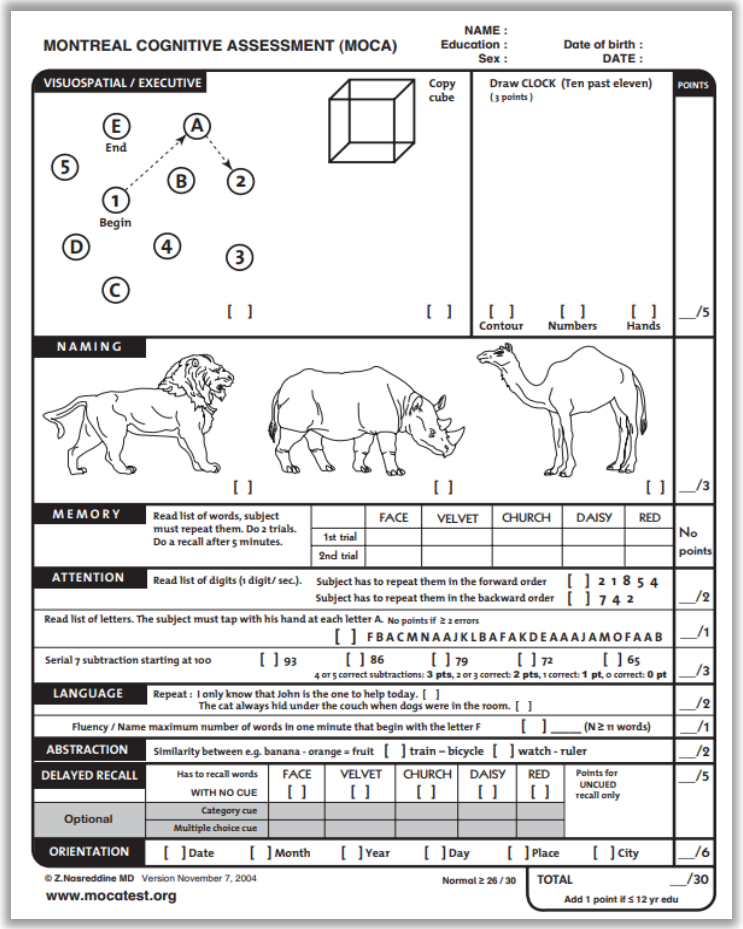
Name:
DOB:
Hospital Number:

One point for each answer	DATE:		
ORIENTATION Year Season Month Date Time	...../ 5	...../ 5	...../ 5
Country Town District Hospital Ward/Floor	...../ 5	...../ 5	...../ 5
REGISTRATION Examiner names three objects (e.g. apple, table, penny) and asks the patient to repeat (1 point for each correct. THEN the patient learns the 3 names repeating until correct).	...../ 3	...../ 3	...../ 3
ATTENTION AND CALCULATION Subtract 7 from 100, then repeat from result. Continue five times: 100, 93, 86, 79, 65. (Alternative: spell "WORLD" backwards: DLROW).	...../ 5	...../ 5	...../ 5
RECALL Ask for the names of the three objects learned earlier.	...../ 3	...../ 3	...../ 3
LANGUAGE Name two objects (e.g. pen, watch).	...../ 2	...../ 2	...../ 2
Repeat "No ifs, ands, or buts".	...../ 1	...../ 1	...../ 1
Give a three-stage command. Score 1 for each stage. (e.g. "Place index finger of right hand on your nose and then on your left ear").	...../ 3	...../ 3	...../ 3
Ask the patient to read and obey a written command on a piece of paper. The written instruction is: "Close your eyes".	...../ 1	...../ 1	...../ 1
Ask the patient to write a sentence. Score 1 if it is sensible and has a subject and a verb.	...../ 1	...../ 1	...../ 1
COPYING: Ask the patient to copy a pair of intersecting pentagons	...../ 1	...../ 1	...../ 1
TOTAL:	...../ 30	...../ 30	...../ 30

MMSE scoring
24-30: no cognitive impairment
18-23: mild cognitive impairment
0-17: severe cognitive impairment

Oxford Medical Education

Montreal Cognitive Assessment (MOCA)



MONTREAL COGNITIVE ASSESSMENT (MOCA)

NAME :
Education :
Sex :
Date of birth :
DATE :

VISUOSPATIAL / EXECUTIVE — Copy cube — Draw CLOCK (Ten past eleven) (3 points) — POINTS — /5

NAMING — [ ] [ ] [ ] — /3

MEMORY — Read list of words, subject must repeat them. Do 2 trials. Do a recall after 5 minutes. — FACE VELVET CHURCH DAISY RED — 1st trial, 2nd trial — No points

ATTENTION — Read list of digits (1 digit/ sec.). Subject has to repeat them in the forward order [ ] 2 1 8 5 4. Subject has to repeat them in the backward order [ ] 7 4 2 — /2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors. [ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B — /1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65. 4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt — /3

LANGUAGE — Repeat : I only know that John is the one to help today. [ ] The cat always hid under the couch when dogs were in the room. [ ] — /2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] ____ (N ≥ 11 words) — /1

ABSTRACTION — Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler — /2

DELAYED RECALL — Has to recall words WITH NO CUE — FACE [ ] VELVET [ ] CHURCH [ ] DAISY [ ] RED [ ] — Points for UNCUED recall only — /5

Optional — Category cue; Multiple choice cue

ORIENTATION — [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City — /6

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Normal ≥ 26 / 30

TOTAL /30
Add 1 point if ≤ 12 yr edu

Exclusion Criteria

Members must meet one of the exclusion criteria below to qualify for PIC:

1. The member can be safely maintained and effectively treated at a less-intensive level of care.
2. The member exhibits serious and persistent mental illness but is not in an acute exacerbation of the illness.
3. A medical condition that warrants a medical/surgical setting for treatment, regardless of the psychiatric presentation.
4. The primary problem is not psychiatric. It is social, legal, or medical problem without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration, the justice system, or for respite or housing.
5. Medical co-morbidities unable to be safely managed in this specialty setting.
6. No behavioral control in the context of traumatic brain injury, intellectual disability, pervasive developmental disorder, dementia, or other medical condition without indication of acute crisis related to a diagnosis listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

Discharge Criteria from Acute PIC

Any of the following are acceptable for discharge for PIC level of care:

1. The member no longer meets continuing stay criteria for acute PIC services but does meet admission criteria for general inpatient mental health services or another level of care where the member can be safely treated.
2. Treatment plan goals and objectives have been substantially met and/or a safe, continuing care program can be arranged and deployed at a less-intensive level of care.
3. The member is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care.
4. The need for high-intensity of services is the result of a chronic condition, and the member requires transfer to a long-term care setting for ongoing treatment.

Case Studies

The following information is provided to assist Iowa Hospitals and their medical staff, MCOs and the State of Iowa in learning about, thinking through and implementing the new Acute Psychiatric Intensive Care Services legislation. Case examples are fictitious amalgamations of real Iowans.

How to Conduct a Case Study

Start by considering if a patient potentially qualifies for this additional payment and consider these four factors:

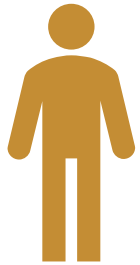
1. The patient must be an active Iowa Medicaid Member or has resumptive eligibility.
2. The patient must be between 18 and 64 years old.
3. The patient must have a serious mental illness (a) diagnosed with a DSM mental illness (b) that illness must be causing serious functional impairment.
4. The patient must have a current, severe, imminent risk of serious harm to self or others.

Additional Considerations:

1. The patient must be admitted to the hospital the provider works at. Patients being served in clinics or hospital outpatient departments (HODs), including the Emergency Department, **do not qualify.**
2. While the patient is likely being cared for on an inpatient behavioral health/psychiatric floor, the PIC rules do not require it. Patients in med/surg or ICU hospital beds are eligible if they meet the other criteria.

Case Study Example

Pt. I



- "Larry" is 56-year-old male, military veteran and guns right advocate brought to the emergency department by his 80-year-old mother on a Saturday morning at 6 a.m. His mother says that her son "has been drinking again," and that "he smashed up the living room after talking with his ex-wife. He's been in a bad place for two weeks or so."

- Emergency department staff asked Larry to change into safety scrubs, per protocol, but he declined. Staff asked to search his possessions and his person, and he furiously declined and began to loudly recite the Constitution of the United States. He was noted to have slurred speech and was repeating the same lines over and over.

- Staff called a public safety officer to assist as the patient continued to be disruptive and uncooperative. Staff insisted patient change out of his clothes and into scrubs for safety reasons.

- Larry became belligerent towards staff, shouting profanity and verbally threatened them. He then lunged and attempted to grab at a staff member and managed to scratch a nurse's eye. Staff then had to place the patient in a physical hold to avoid further harm.

- Larry was escorted to one of the special emergency department safe rooms to detox. He cooperated with taking oral medication and fell asleep a short time later.

Case Study

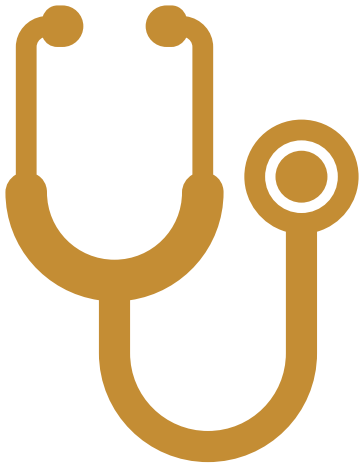
Pt. 2

- Larry's doctor, "Dr. Right", began his shift in the emergency department just before noon. He reviewed Larry's medical record and met with him.
  - Lab results showed a high blood alcohol level of .347. Dr. Right noted that Larry had been seen at this hospital prior for knee surgery one year ago.
  - According to notes by his primary care provider, Larry's problem list included alcohol use disorder, diabetes, depression and hypertension.
  - During interview with the patient, Larry was very quiet, somber, disinterested and difficult to engage to the point of ignoring Dr. Right.

- Screening tools for anxiety show Larry as low risk, but the Columbia suicide screening tool is in the high risk/red. This includes Larry's thoughts, plan and ability to carry out suicide. A one-on-one safety assistant was assigned to Larry at the time of the initial screening. Dr. Right recommended admission to an acute adult behavioral health unit.

- Another patient's discharge was planned for 6 p.m. that evening and Larry would be able to move to the unit at that time later that night. Larry was his own decision maker and signed paperwork without reading it or listening to the staff attempting to talk with him about what it said. He was admitted to the inpatient unit that evening and the safety assistant was discontinued.

- The attending provider completed an H&P the following morning. Larry was diagnosed with adjustment disorder with mixed disturbance of emotions and conduct; alcohol use disorder and suicidal ideation.



Case Study Discussion

Do you think Larry was qualified for PIC services?

Case Study Explanation

- The patient would not qualify for PIC for the first day, with the services provided in the emergency department. Larry was moved to a unit at 6 p.m. and the safety assistant service was ended. Knowing the service was ended and without any additional documentation of challenges – PIC would not be approved for day two. The criteria, specifically those in Part 3, are not met.

- Below is Larry's behavior may warrant PIC:
  - Larry is a veteran and gun rights advocate acting irrationally.
  - He scratched a nurse's eye.
  - Screening tools for anxiety show low risk, but Columbia suicide screening tool is high risk/red, including thoughts, plan and ability to carry out suicide.

- This example provides us with the opportunity to point to the criteria in Part 3 and provide examples of what additional factors and documentation would be needed to demonstrate his need for PIC.

Billing and Coding

Prior Authorizations

Initial authorizations will likely be approved for one to three (1-3) days.

Authorizations will be for a minimum of one (1) day.

The member needs authorization for movement between psychiatric levels of care.

Rate Calculations

Pt. I

Iowa Inpatient System – Psych PIC Per Diem Model *Claims data falls within cost report periods.	
Per Diem Rates	**65-35 Model**
PIC Rate Per Diem Increase	42.59%
Estimated Increase in Payments Per Diem	$5,922,726
DRG Rates	**65-35 Model**
Statewide DRG per Diem Rate Add-On	$520.47
Estimated Increase to Payments - DRG	$3,754,693
Total Estimated Increase in Payments	$9,677,419

Rate Calculations

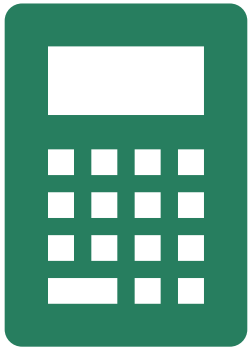
Pt. 2

For providers reimbursed on an inpatient psychiatric per diem rate, providers will receive provider specific rates for the PIC reimbursement.

- For these providers' PIC rate, it will be an add on reimbursement to the base inpatient psychiatric per diem rate as determined by HHS and submitted to the MCOs through standard regulatory rate sharing files.

For providers reimbursed on a DRG, reimbursement is as follows:

- To ensure the PIC reimbursement methodology results in more payment than the standard DRG rate and outlier methodology, rate calculations will include all covered inpatient days and covered charges in the outlier calculation on the claim.



Billing

The following two billing codes are used to claim the PIC rate:

Revenue code 0204

CPT Code 90899

Both codes are required on the claim for tracking purposes. The PIC revenue code should be reported as an additional line item for PIC qualifying days on claims.

Pay for a full day (not paid by hour/minutes).

Claims will have lines for PIC days and for general days.

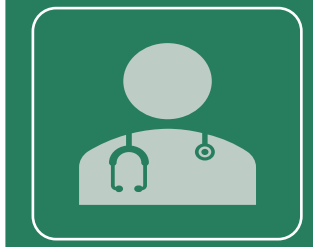
There should be only one bed revenue code billed per day.

Bill the status at midnight for the day (if PIC at midnight, then PIC day, if general psych at midnight, then general psych day).

Goals

Implementation Monitoring

Reduce the amount of time that individuals await placement in emergency department settings.



Reduce the number of individuals turned away from hospital psychiatric inpatient placement due to inability to staff/treat individuals with specialized needs.

Leverage the current beds available that remain "open".

- Need to consider the right level of care available (staffed beds) in the right places at the right times.

Developing a monitoring plan to evaluate:

- Psychiatric bed status
- Claims data
- Appeals data
- Utilization management case reviews

Resources

Find Resources on our Website

- https://hhs.iowa.gov/ime/providers/claims-and-billing
- Past training recordings:
  - Training #1
  - Training #2

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